CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT

1.1 Overview of the Resident Assessment Instrument (RAI)

Providing care to residents with post-acute and long-term care needs is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from all disciplines to develop individualized care plans. The Resident Assessment Instrument (RAI) helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being.

The RAI helps facility staff to look at residents holistically - as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this very emphasis on quality of care and quality of life. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication.

Persons generally enter a nursing facility due to functional status problems caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. The individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment and/or rehabilitation is needed for residents to maintain and/or restore function or to live safely from day to day. While we recognize that there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (Quality of Care) and maintain their sense of individuality (Quality of Life). This is true for long-term residents, as well as the resident in a rehabilitative program anticipating return to a less restrictive environment.

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI simply provides a structured, standardized approach for applying a problem identification process in long-term care facilities. **The RAI should not be, nor was it ever meant to be, an additional burden for nursing facility staff**.

All good problem identification models have similar steps:

a. **Assessment** - Taking stock of all observations, information and knowledge about a resident; understanding the resident's limitations and strengths; finding out who the resident is.

b. Decision-making - Determining the severity, functional impact, and scope of a resident's problems; understanding the causes and relationships between a resident's problems; discovering the "what's" and "whys" of resident problems.

c. Care Planning - Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

d. Implementation - Putting that course of action (specific interventions on the care plan) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the "how" and "when" of resident care.

e. Evaluation - Critically reviewing care plan goals, interventions and implementation in terms of achieved resident outcomes and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, either improvement or decline.

This is how the problem identification process would look as a pathway. This manual will feature this pathway throughout the chapter discussions.

Assessment (MDS/other) → Decision-Making (RAPs/other) → Care Plan Development → Care Plan Implementation → Evaluation

If you look at the RAI process as solution oriented and dynamic, it becomes a richly practical means of helping facility staff to gather and analyze information in order to improve a resident's quality of care and quality of life. In an already overburdened structure, the RAI offers a clear path toward utilizing all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to understanding the RAI process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff, across all shifts, are involved in its "hands on" approach. The result is a process that flows smoothly from one component to the next and allows for good communication and uncomplicated tracking of resident care. In short, it works!

Since the RAI has been implemented, facilities that have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

Residents Respond to Individualized Care. While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, linked with appropriate resident specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or deteriorated at a slower rate. Facilities report that as individualized attention increases, resident satisfaction with quality of life is also increased.

Staff Communication Has Become More Effective. When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using the Resident Assessment Protocols (RAPs)) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

Resident and Family Involvement in Care Has Increased. There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.

Increased Clarity of Documentation. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

It is the intent of this manual to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help facilities achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 that made recommendations to improve the quality of care in nursing facilities, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

With the consistent application of item definitions, the RAI ensures standardized communication both within the facility and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.2 Content of the RAI for Nursing Facilities

The RAI consists of three basic components:

1. **Minimum Data Set (MDS) Version 2.0**,

2. **Resident Assessment Protocols (RAPs)**, and

3. **Utilization Guidelines** specified in State Operations Manual (SOM) Transmittal #272.

Utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS)**. A core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. **A copy of the MDS Version 2.0 can be found at the end of this chapter.**

- **Resident Assessment Protocols (RAPs)**. The RAPs are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. RAPs help identify social, medical and psychological problems and form the basis for individualized care planning. The 18 RAPs are explained in detail in Appendix C. There are four components in the RAPs protocols:

  - ***Triggers*** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation.

  - The ***Trigger Legend*** is a two-page form that summarizes all of the triggers for the 18 RAPs. It is not a required form that must be maintained in the resident's clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS assessment.

  - The ***RAPs*** analysis is performed in accordance with the Utilization Guidelines. The indepth review assists the staff members to draw a conclusion to proceed or not to proceed to the plan of care.

  - The ***RAPs Summary Sheet*** documents the decisions made during this evaluation process on whether or not to proceed to care planning.

- **Utilization Guidelines**. Instructions concerning when and how to use the RAI. Application of the RAPs and the Utilization Guidelines is discussed in detail in Chapter 4.

1.3 Additional Uses of the Minimum Data Set

Over the course of time, the role of the MDS has expanded beyond its primary purpose as an assessment tool used to identify resident care problems that are addressed in an individualized care plan. Data collected from MDS assessments is used for the Medicare reimbursement system, many

State Medicaid reimbursement systems, and to monitor the quality of care provided to nursing facility residents. The MDS instrument has also been adapted for the hospital swing bed program. Swing bed providers are required to complete a unique 2-page MDS for the Medicare Prospective Payment System (PPS).

Medicare and Medicaid Payment Systems

The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. Chapters 2 and 6 provide more detailed information on the Medicare Prospective Payment System, assessment requirements, and payment requirements.

Monitoring the Quality of Care

MDS assessment data is also used to monitor the quality of care in the nation's nursing facilities. A set of 24 quality indicators (QIs) was developed by researchers to assist State staff to identify potential care problems in a nursing facility. CMS is currently evaluating the usefulness of these indicators and is considering additions and modifications to further enhance the effectiveness of the QI system. The QI data is available to providers to assist them in their ongoing quality improvement activities, to surveyors to assist in identifying potential problem areas that should be addressed during the survey process, and to CMS for long-term quality monitoring and program planning.

Consumers are also able to access information about every Medicare and Medicaid certified nursing facility in the country. The Nursing Home Compare tool available at **www.medicare.gov** provides the following sections of detailed information:

- **About the Nursing Facility:** Including the number of beds and type of ownership.
- **About the Nursing Facility Inspection:** Including health deficiencies found during the most recent State nursing facility survey and from recent substantiated complaint investigations.
- **About Nursing Facility Staff:** Including the average number of hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per resident per day.
- **About the Quality of Care Received at the Facility:** In 2002, CMS began a new program called the Nursing Home Quality Initiative (NHQI). The purpose of this program is to provide consumers with information on the quality of care delivered in nursing facilities to help them make informed decisions. CMS expanded the original quality indicators to a set of 39 quality measures. These quality measure domains include pain and measures for the short-stay and post-acute population. A subset of 10 quality measures are posted on the Nursing Home Compare web site, a CMS developed internet search tool to allow comparisons between nursing facilities. The public reporting initiative was successfully piloted in six states, and, beginning in November 2002, was expanded to all fifty states as well as to U.S. territories that have Medicare or Medicaid certified nursing facilities.

The Nursing Home Compare web site is:

http://www.medicare.gov/nhcompare/home.asp.

1.4 Suggestions for the Use of this Manual

This manual is designed to meet the needs of nursing facility staff who are both skilled in the use of the RAI process and staff who are just beginning to work with it.

This revised manual includes information about:

- MDS automation
- Reimbursement
- Quality monitoring applications

It also includes new case studies and expanded clarifications for the original item-by-item section information of the October 1995 Version 2.0 Long-Term Care Resident Assessment Instrument User's Manual and "how-to" directions for completing the RAP review process and documentation requirements.

The following fundamental concepts associated with the RAI are interwoven as themes throughout this manual:

- The resident is an individual with strengths, as well as functional limitations and health problems.
- The RAPs are utilized to identify possible causes for each problem area, and guidance for further assessment and resolution or intervention.
- An interdisciplinary approach to resident care is vital - both in assessment and in developing the resident's care plan.
- Good clinical practice requires solid, sound assessment.

In essence, this manual promotes a step-by-step system of assessing resident needs and functional status based on standardized definitions of items (the MDS). It then helps you think through possible reasons for and risk factors that contribute to a resident's clinical status (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that is based on specific, individual characteristics.

1.5 Clarifications and Revisions to the Manual

Since the publication of the MDS 2.0 manual in October 1995, a number of additional systems and monitoring protocols that use MDS data have been developed and implemented, such as SNF PPS, nursing facility quality of care monitoring, and the public reporting of nursing facility quality of care information.

In addition, CMS established a process for answering questions and clarifying MDS coding instructions for nursing facility staff. CMS posted responses to questions on their web site. These responses are now incorporated into this manual. The instructions in this revised manual incorporate and supercede previous Q&A documents.

CMS recognizes that the publication of this revised manual will not preclude future questions or the need for more clarification about MDS items. Therefore, CMS has developed a procedure to review, respond and distribute clarifications to the MDS coding process.

STEP 1: If clinicians have a question about a particular MDS item, they should first review the manual and then contact their State RAI Coordinator for a clarification. If necessary, the State RAI Coordinator will contact the appropriate CMS staff if he/she is not able to answer a specific question.

STEP 2: CMS will determine if a clarification about an item is needed and will post new clarifications on the CMS web site. If a clarification is posted on the official CMS web site, then it can be considered policy. CMS will develop a process to periodically update the manual and incorporate additional clarifications. Clinicians should monitor the CMS web site at: **http://www.cms.hhs.gov/medicaid/mds20** for these clarifications

1.6 Statutory and Regulatory Basis for the RAI in Nursing Facilities

Minimum Data Set (MDS): The statutory authority for the MDS Version 2.0 and the Resident Assessment Instrument (RAI) is found in Section 1819(f)(6)(A-B) for Medicare and 1919 (f)(6)(A-B) for Medicaid in the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the Social Security Act required the Secretary of the Department of Health and Human Services (the Secretary) to specify a minimum data set of core elements for use in conducting comprehensive assessments. It furthermore required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995. Revision #22, issued December 8, 2000, required nursing facilities to implement the September 2000 update of the Resident Assessment Instrument (RAI).

Federal requirements at 42 CFR 483.20(b)(1)(i) -- (F272) require that facilities use an RAI that has been specified by the State. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident's functional capabilities and helps staff to identify health problems. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data from the facility to the State MDS database. (Detailed submission requirements are located in Chapter 5.)

1.7 State Designation of the RAI for Nursing Facilities

All comprehensive RAIs authorized by states include at least the Centers for Medicare & Medicaid Services' (CMS's):

- **MDS Version 2.0 (with or without optional Sections S, T, U)**
- **Resident Assessment Protocols (RAPs), including**
  - **Triggers**
  - **Trigger Legend**
  - **RAPs Summary Sheet**
- **Utilization Guidelines**

Each state must have CMS approval for the State RAI. CMS's approval of a state's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. CMS's approval of the RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). States must use all Federally required MDS items (see Section 1.9) but have some flexibility in adding one or more optional sections (Sections S, T and U) and in selecting a Quarterly assessment instrument.

In addition to approving the State's RAI, CMS must also pre-approve the Quarterly assessment designated by each state. Effective July 1, 2002, CMS approved the Medicare Prospective Payment Assessment Form (MPAF) for use as a Quarterly assessment. States choosing to use the MPAF form as the State Quarterly assessment do not need prior CMS approval. The state is only required to notify CMS that the MPAF has been designated as the State Quarterly assessment.

If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the state can ensure that the facility's RAI form in the resident's record accurately and completely represents the State's RAI as approved by CMS in accordance with 42 CFR 483.20 (b). This applies to either pre-printed forms or computer generated printouts. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions).

Additional information about State specification of the RAI, variations in format and CMS approval of alternative State instruments can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual, Transmittal #272 issued April 1995. Revision #22 issued December 8, 2000 updated RAI requirements and mandated nursing facilities to implement the Version 2.0 September 2000 update of the RAI.

1.8 Protecting the Privacy of MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities under the Conditions of Participation (COP). By regulation at CFR 483.75(L)(2)(3) and 483.75(L)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. The Privacy Act can be found at **www.usbr.gov/laws/privacy.html.**

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the State MDS database. The notice shown on Page 1-11 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under OBRA or for Medicare payment purposes.

Contractual Agreements

Providers, who are part of a chain, may release data to their corporate office or parent company but not to other providers within their chain organization. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the CFR at 483.10(e)(3)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

NURSING FACILITIES
PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits the information to CMS.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators(TPA),employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

1.9 The Components of the Minimum Data Set (MDS)

Minimum Data Set

The MDS is completed on all residents in Medicare or Medicaid certified facilities. A mandated assessment schedule is discussed in Chapter 2. In addition, states may establish additional MDS requirements. For specific information on State requirements, contact your State RAI Coordinator (see Appendix B).

Since the requirements for Medicare PPS went into effect, assessments may be referred to as either a "comprehensive" or "full" assessment. To clarify this terminology, the comprehensive assessment is a clinical assessment that requires the full MDS, RAPs and Utilization Guidelines. Comprehensive assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines. Comprehensive assessments are required within 14 days of the admission, annually, when there has been a significant change in clinical status, and when the facility does a Significant Correction of a Prior Full assessment.

When the term "full assessment" is used, it includes the MDS required items A through R (plus any State-required items). A full assessment is distinguished from a comprehensive assessment (RAI) in that the RAPs and care planning are not completed when the full assessment is completed for a Medicare assessment.

Of course, the facility's right to care plan is not restricted to the RAI mandated requirements. Facilities may expand upon these requirements, when appropriate, to fully assess and care plan for an individual.

The required components of the MDS are as follows:

SECTION AA - The Basic Assessment Tracking Form

This form contains Identification Information Items 1-9, which consists of identifying information needed to uniquely identify each resident, the nursing facility in which he or she resides, the reason(s) for assessment; and Items AA9 a-l, Signatures of Persons Completing a Portion of the MDS or Tracking form. The information contained on this form must accompany each comprehensive, full, MPAF, or Quarterly assessment, as well as every Distcharge and Reentry Tracking form, submitted electronically to the State MDS database. This includes Federally required assessment records, (e.g., Admission, Annual, Significant Change in Status, and Quarterly assessments), as well as assessments required for Medicare or by the State. This section also contains the Attestation Statement that staff members must sign and date attesting to the accuracy of the portions of the MDS completed by each member of the interdisciplinary team.

SECTIONS AB, AC, AD - Background (Face Sheet) Information at Admission Form

This form contains Sections AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This information is to be completed at the

time of the resident's initial admission to the nursing facility. A new Face Sheet is also required to be completed, along with an Admission assessment, for an individual who returns to the facility after a discharge in which return was not anticipated. CMS's clinical policies, as well as data specifications, allow Face Sheet information to be updated and submitted after the Admission assessment is completed and transmitted. This means that Face Sheet information can be transmitted with any of the Federally required records (those indicated by the codes under AA8a) or the assessments required for Medicare (those indicated by the codes under AA8b). The only instance in which Face Sheet information cannot be updated is from those assessments required by the State (AA8a = "0" and AA8b = "6").

SECTIONS A-Q - Clinical Assessment

Sections A-Q contain the clinical data items used to assess residents in the nursing facility. Section A9 is where staff sign that they have completed portions of the assessment and agree to the Attestation Statement.

SECTION R – Signature and Completion Date

Section R contains the signature of the RN coordinating the assessment. This is the section that records participation of the resident, family and/or significant other in the assessment process.

SECTION S - State Section

Some states have added items to the core MDS that must be completed for each resident when a comprehensive assessment, full, MPAF, or Quarterly is required. Thus, while the basic MDS form is the standard foundation for states, you may find that other items have been added at the end of the form (in Section S) in your state. Contact your State RAI Coordinator for State-specific requirements. A list of State RAI Coordinators is found in the Appendix B.

SECTION T – Supplement

Required for all Medicare assessments. Optional at State discretion for all other types of assessments.

SECTION U – Medications

Not used by CMS. Can be required by the State.

SECTION V - Resident Assessment Protocol Summary

Section V contains the form used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether or not a care plan has been developed for each RAP area. Note that the RAP need not have triggered for a care plan to be developed for that particular area. A RAP Summary form must be completed each time a comprehensive RAI is required under the Federal schedule. If a care plan is written from a non-triggered RAP, it should be noted on the RAP Summary form.

Quarterly Assessments

Additionally, states must specify a Quarterly assessment form, for use by facilities that includes at least the items on the CMS-designated form. The Quarterly assessment contains the mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serves as the minimum requirement for Quarterly assessments within each State's RAI. Some states have mandated an expanded Optional Quarterly assessment form. CMS has published two optional versions that states may require. A state may also require a full assessment on a quarterly basis. Again, contact your State RAI Coordinator for State specifics. States have the following options for the Quarterly Assessment:

- **Minimum Required MDS Quarterly Assessment**
- **MDS Quarterly Assessment Form Optional Version for RUG-III or Optional Version for RUG-III 1997 Update**
- **Full MDS Assessment**
- **Medicare Prospective Payment Assessment Form (MPAF)**

Copies of the Quarterly assessment options available to the states are included at the end of this Chapter.

Discharge and Reentry Tracking Forms

Facilities are required to submit the information contained in two additional forms to notify the State if a resident is "discharged" or "reenters" the MDS system. Both the Discharge Tracking form and the Reentry Tracking form contain Section AA (Identification Information) Items 1-7, a subset of codes from Item 8 (Reason for Assessment), and Item 9. The Discharge Tracking form also contains items from Section R related to discharge status and date, along with two items from Section AB, that are required only for individuals whose stay is less than 14 days. The Reentry Tracking form contains items from Section A related to the date and point of reentry. States may opt to require Section S information to accompany Discharge and Reentry Tracking forms. A detailed discussion of the Discharge and Reentry Tracking process is in Chapter 2.

Medicare Assessments

Nursing facilities perform a comprehensive MDS assessment when the Medicare assessment is combined with any assessment required for clinical and/or care planning purposes, i.e., all OBRA assessments except the Quarterly. In 2002, a customized version of the MDS form was developed to minimize the facility's data collection requirements. This customized Medicare Prospective Payment System Assessment Form (MPAF) may be used when the assessment is performed solely for payment purposes (see Chapter 2 for details).

Resident Assessment Protocols (RAPs)

The **triggers** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who either have or are at risk for developing specific functional problems and require further evaluation using Resident Assessment Protocols (RAPs) designated within the

State specified RAI. MDS item responses that define triggers are specified in each RAP and on the trigger legend form. Not all items assessed on the MDS are automatic triggers, e.g., use of side rails at P4. However, the RAP may be used to evaluate those items that are not automatic triggers. Turn to the RAPs (in Appendix C) to review these items and the accompanying RAP Guidelines. Once you are familiar with the RAP triggers and guidelines, the trigger legend form serves as a useful summary of all RAP triggers. The **trigger legend** summarizes which MDS item responses trigger individual RAPs and has been designed as a helpful tool for facilities if they choose to use it. **It is a worksheet, not a required form**, and does not need to be maintained in each resident's clinical record.

The RAPs provide structured, problem-oriented frameworks for organizing MDS information, and additional clinically relevant information about an individual's health problems or functional status. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an unconventional manner for the RAP in question? Clinical staffs are responsible for answering questions such as these. The information from the MDS and RAPs forms the basis for individualized care planning. The RAPs Summary form documents the decisions made during this evaluation process whether or not to proceed to care planning.

Utilization Guidelines

The **Utilization Guidelines** are instructions concerning when and how to use the RAI. Once a RAP has been triggered, use the utilization guidelines to evaluate the problem and determine whether or not you continue to care plan for it. The Utilization Guidelines for Version 2.0 of the RAI were published by CMS in the State Operations Manual[1] Transmittal #272, and are discussed in detail in Chapter 4.

The individual resident's care plan must be evaluated and revised, if appropriate, each time a comprehensive or Quarterly assessment is completed. Facilities may either make changes to the original care plan or develop a new care plan.

Additional information relevant to a resident's status, but not necessarily included on the RAI, may be documented in the resident's active record. This documentation should include progress notes or facility specific flow sheets.

1.10 Applicability of RAI to Facility Residents

The clinical requirements for the resident assessment instrument are found at 42 CFR 483.20 and are applicable to all residents in certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, or payment category.

[1]The SOM is a reference only; it is not necessary for effective use of the RAI. The SOM can be ordered from the National Technical Information Service (NTIS); PB# 95-950007; (703) 487-4650.

An RAI must be completed for any resident residing in the facility **longer than 14 days**, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities or Medicaid (Title 19) nursing facilities. This includes a certified Skilled Nursing Facility (SNF) or Nursing Facility (NF) and certified SNFs or NFs in hospitals, regardless of payment source.

- **Hospice Residents.** When an SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between the hospice and long-term care facility staff with the consent of the resident. In these situations, the hospice team should participate in completing the RAI.

- **Short-term stay or respite residents.** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, you must follow the OBRA assessment schedule and tracking document requirements. If the respite resident is in the facility for fewer than 14 days, no assessment is due. Facilities that have short-term or respite residents should follow the instructions in Chapter 2 for completion of assessments and tracking forms.

  Given the nature of short stay or respite admissions, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge (e.g., the physician may not be available, or the family may not be able to provide information on the resident's Customary Routine). In that case, the "no-information" convention should be used ("-") (See Chapter 3 Section 3.2 for more information). For respite residents who come in and out of the facility on a relatively frequent basis and readmission can be expected, the resident may be discharged to "extended" leave status (Discharged-return anticipated). This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred in the intervening period.

  Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet the resident's needs upon or shortly after admission. In addition, if the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.

- **Special populations (e.g. pediatric or residents with a psychiatric diagnosis).** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.

- **Long-Term Care Facilities.** Additional assessments are required for Medicare beneficiaries in a SNF Part A stay. The MDS is used to determine the Resource Utilization Group (RUG-III) that is used to calculate payment under the SNF PPS. See Chapter 2 for detailed information on Medicare assessments.

- **Swing bed facilities.** Swing bed hospitals providing Part A skilled nursing facility-level services were phased into the skilled nursing facility prospective payment system (SNF PPS) starting July 1, 2002. Beginning on the first day of each hospital's cost reporting year on and after July 1, 2002, swing bed hospitals must complete a customized two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. A separate Swing Bed MDS Assessment Training Manual has been developed and can be found on the CMS website at:

  http://www.cms.hhs.gov/providers/snfpps/sbtraining.asp.

Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a state from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.

1.11 Facility Responsibilities for Completing Assessments

NEWLY CERTIFIED NURSING FACILITIES

Nursing facilities must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed *as if the beds were already certified.* Then, assuming a survey where the SNF has been determined to be in substantial compliance, the facility will be certified effective on the last day of the survey. If the facility completed the Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.

Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 (of the covered Part A stay) when establishing the Assessment Reference Date for the 5-Day Medicare assessments. For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Assuming a survey where the SNF has been determined to be in substantial compliance, the SNF should implement the Medicare assessment schedule (for any resident in a bed that is pending certification) using the last day of the survey as Day 1.

If the SNF is already certified and is adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification. Medicare and Medicaid residents should not be placed in a bed until you are notified that the bed has been certified.

CHANGE IN OWNERSHIP

There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment

schedule for existing residents continues, but the facility uses the new provider number. For example, if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the new provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the new provider number.

There are situations where the new owner will not assume the assets and liabilities of the previous owner. In these cases, each resident is considered a new admission effective on the date of sale. New assessment schedules will be required for all residents in certified beds.

TRANSFERS OF RESIDENTS

Any time a resident is admitted to a new facility (regardless of whether or not it is a transfer within the same chain), a new comprehensive assessment must be done within 14 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care. However, when the second facility admits the resident, the MDS schedule starts from the beginning with an Admission assessment, and if applicable, a 5-Day Medicare assessment. The admitting facility should of course look at the previous facility's assessment (in the same way they would review other incoming documentation about the resident) for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new assessment for the purpose of planning care within the facility to which the resident has been transferred. The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper--that is, the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff. States may have other requirements from a payment perspective. Therefore, facilities should contact their survey agency as well for clarification.

In instances where there has been a massive transfer of new residents to a nursing facility secondary to natural disasters (flood, earthquake, fire), a new MDS must be completed by the admitting facility. The admitting facility should try to complete the MDS within 14 days of transfer if at all possible. If the admitting facility is having problems meeting the requirement they should contact their State agency to discuss the situation and receive guidance about any extensions in the 14-day time factor.

1.12 Completion of the RAI

PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulations[2] require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical

[2] 42 CFR 483.20 (h)--(F 278)

backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

The RAI must be conducted or coordinated by an RN who signs and certifies the completion of the assessment[3]. If a facility does not have an RN on its staff (i.e., has an RN waiver granted under 42 CFR 483.30 (c) or (d) -- F354) it must still provide an RN to complete the RAI. This requirement can be met by hiring an RN specifically for this purpose. In this situation, the LPN responsible for the care of the resident should participate in the resident assessment process and the development of the resident's care plan.

The attending physician is also an important participant in the RAI process. The facility needs the physician's evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the MDS and RAPs and is a member of the mandated interdisciplinary team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to integrate the RAI into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following:

- Train facility staff on the circumstances that require a comprehensive assessment and the staff that should be involved.

- Assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, attending physicians, social workers, activities specialists, physical, occupational, or speech therapists, dietitians, and pharmacists.

- Assure that residents and their families are actively involved in the information sharing and decision-making processes.

- Assure that the care planning component is developed with input from all staff.

- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the accuracy of this information or the need to perform a significant change reassessment.

[3] 42 CFR 483.20 (i)(1)--(F 278)

- Instruct staff on how to integrate MDS information with existing facility resident assessment and care planning practices.

1.13 Sources of Information for Completion of the MDS

The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, interacting with the resident and direct care staff validates information in the resident's record.

The following sources of information must be used in completing the MDS. Although not required, the review sequence for the assessment process generally follows the order below:

- **Review of the resident's record** - Depending on whether or not the assessment is an admission or follow-up assessment, the review could include: preadmission, admission, or transfer notes; current plan of care; recent physician notes or orders; documentation of services currently provided; results of recent diagnostic or other test procedures; monthly nursing summary notes and medical consultations for the previous 60-day period; and a record of medications administered for the prior 30-day period.

- **Communication with and observation of the resident.**

- **Communication with direct-care staff (e.g., nursing assistants, activity aides) from all shifts.**

- **Communication with licensed professionals** (from all disciplines) who have recently observed, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to document their impressions of the resident.

- **Communication with the resident's physician.**

- **Communication with the resident's family** - Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, the resident may request that someone else who is very close to him/her be contacted.

REVIEW OF THE RESIDENT'S RECORD

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

At admission, record review includes an examination of notes written in the first 2 weeks (assuming the full 14-day period is used to complete the assessment), documentation that came with the resident at admission, facility intake forms (e.g., social service notes), and any preadmission test results including copies of the MDS and RAPs from another nursing facility if the resident was transferred. Obviously, transcribing the previous facility's MDS is inappropriate.

Subsequent reassessments should focus on recorded information from earlier MDS assessments and Quarterly assessments, written information from the previous 3-month period, and notes made during the prior 30-day period.

The following are important considerations when reviewing the resident's record:

- **Review the information documented in the record, keeping in mind the required MDS definitions.** Make sure that assumptions based on the record are compatible with MDS definitions (e.g., resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly, according to the MDS, a resident, who stays "dry" with a catheter may be considered continent).

- **Make sure that the information taken from the record covers the same observation period as that specified by the MDS items.** The MDS refers to specific time frames for each item; for example ADL status is based on resident performance over a 7-day period. To ensure uniformity, the MDS has an Assessment Reference Date (A3a) that establishes a common reference end-point for all items. Consequently, it is necessary to pay careful attention to the notes regarding time frames for each section of the MDS and also to the Item-by-Item instructions in Chapter 3.

- **Be aware of discrepancies and view the record information as preliminary only.** Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets), where different types of information are maintained in the clinical record, and more importantly, what information is missing.

- **Where information in the record is sufficiently detailed and conforms to MDS descriptions and time periods, complete the MDS items.** A few MDS items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e., the resident, the resident's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a suggested work tool only.

- **As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.**

COMMUNICATION WITH AND OBSERVATION OF THE RESIDENT

The resident is a primary source of information and may be the only source of information for many items (e.g., customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many MDS items will not be documented elsewhere in the clinical record, and the completed MDS may ultimately be the single source of documentation about these issues.

Become familiar with the MDS items to make communication and observation of the resident an ongoing everyday activity in the facility. For example, an RN can observe and interact with a resident when medications are given, during meals, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in confirming staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other information obtained from the resident record and facility staff.

To be most efficient, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance as to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. For further information on "Interviewing Techniques" see Appendix D.

It is important to observe, interview and physically assess the resident, and to interview staff. In addition, the MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

Any person completing any MDS section is required to follow the Item-by-Item guidelines in Chapter 3 of this manual that specify sources of information necessary for accurate coding. The process of information gathering should include direct observation of the resident; communication with the resident's direct caregivers across all shifts; review of relevant information in the resident's clinical record; and if possible, consultation with family members who have direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not personally observe for example a behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the MDS form. In addition, the resident's clinical record should support their status as reported on the MDS.

COMMUNICATION WITH DIRECT CARE STAFF

Direct care staff (e.g., nursing assistants and activity aides) having daily, intimate contact with residents is often the most reliable source of information about the resident. Direct care staff talk with and listen to the residents. They observe and assist the resident's performance of ADLs and involvement in activities. They observe the resident's physical, cognitive and psychosocial status

daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- **Be sure to speak with a person who has first-hand knowledge of the resident.** Plan for sufficient time to talk with direct care staff person(s).

- **Start by asking about the resident's performance on ADLs and activities.** What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioral symptoms.

- **Talk with direct care staff across all shifts, if possible.** The information from other shifts may be obtained in other ways as well (e.g., from change-of-shift reports if direct care staff comments are included).

COMMUNICATION WITH LICENSED PROFESSIONALS

Licensed practical nurses (LPNs), RNs, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, dietitians, and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns, and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

COMMUNICATION WITH THE RESIDENT'S PHYSICIAN

The physician's role is central to the overall management and outcome of resident care. The MDS assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders. At the Quarterly assessments and Annual assessments, review the most recent physician orders and notes. Also, review the MDS with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment from the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

COMMUNICATION WITH THE RESIDENT'S FAMILY

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas, and customary routine prior to the first nursing facility admission. This information is particularly necessary when the resident is cognitively impaired or has a great deal of difficulty communicating. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. Facilities need to respect the cognitively intact resident's right to privacy, and should have permission from the individual for staff to ask questions of family members. In most instances, family will not be the sole source of information but will supplement

information from other sources. The assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

1.14 CMS Clarification Regarding Documentation Requirements

CMS has always accepted the MDS as a primary data source, and duplicative documentation is not required. However, clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. For this reason, it is always expected that information contained in the clinical record supports rather than conflicts with the MDS. Completion of the MDS does not remove the facility's responsibility to document a more detailed assessment of particular issues of relevance for the resident. In addition, for the Medicare prospective payment system, documentation must substantiate the resident's need for Part A SNF-level services and his/her response to those services.

Nursing facilities are required to document the resident's care and response to care during the course of the stay, and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment. Always keep in mind that government requirements are not the only or even the major reason for clinical documentation. The MDS has simply codified some documentation requirements into a standard format.

Clinical documentation that contributes to identification and communication of residents' problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals. Good clinical practice has always dictated documentation of certain treatments and conditions such as the amount of IV nutrient intake and the number of minutes of therapy actually provided to a SNF resident. For these types of services, the more detailed documentation needed for good resident care also provides all the data needed to code the MDS. The MDS does not require duplication of the more detailed treatment logs; the data are simply summarized on the MDS.

In addition, it is important to note that CMS does not impose specific documentation procedures to nursing facilities. Some facilities have developed tools to collect data across shifts or throughout an assessment period; e.g., ADL support needs, type and duration of restorative nursing services, etc. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility. These tools may provide more accurate data for MDS reporting and care planning, and may provide real value to the facilities utilizing them. However, these tools are not mandated by CMS or by Fiscal Intermediaries.

When available, State agency and Fiscal Intermediary staff will utilize these data collection tools as part of an MDS validation review. In the absence of this type of documentation, the MDS can still be verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the MDS.

Some states may have regulations that require supporting documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system. If your state requires the MDS to be completed for the Medicaid program, they may have additional documentation requirements. Contact your State agency's Resident Assessment Coordinator or your Medicaid program for State-specific requirements.

1.15 RAI Completion Time Frames

ASSESSMENT COMPLETION TIME FRAMES

Each individual team member who completes a portion of the MDS assessment must sign and certify its accuracy.[4] Each interdisciplinary team member who completes a portion of the MDS assessment signs, dates, and indicates the portion of the assessment he or she completed in AA9. This signature and date should reflect the date of the assessment and may be earlier than the date in R2b. The RN coordinator is required to sign R2b to certify that the MDS is complete.[5] The RN coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the MDS. If the RN does all of the MDS, then the nurse alone would sign and be responsible for certifying accuracy and completeness. An assessment that was signed and dated by all assessors, but not by the RN coordinator, because the RN coordinator is no longer at the facility, should be signed and dated (with the date it is actually signed) by the current RN assessment coordinator.

RAPs COMPLETION TIME FRAMES

An RN coordinator must also sign and date the RAP Summary form at VB1 and VB2, the RAPs Completion Date, to signify completion of the RAI assessment. For the admission assessment, the RN coordinator must sign and date the RAP Summary form at VB1 and VB2 within 14 days of the resident's admission to the facility. There is no Federal requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the clinical record. However, if desired, individual team members may indicate which RAP(s) they completed, list their credentials, and the date it was completed by signing the form wherever there is room to do so in a legible manner. The RN completing the RAP Summary form does not have to be the same RN who completed and signed the MDS assessment.

It is never permissible to certify or backdate RAI forms for another individual on the interdisciplinary team. If an individual who completed a portion of the MDS is not available to sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the RAI when these situations occur.

[4] 42 CFR 483.20 (i)(2)--(F 278)

[5] 42 CFR 483.20 (i)(1)--(F 278)

CARE PLANNING COMPLETION TIME FRAMES

The facility has 7 days after completing the RAI (RAPs Completion Date (VB2)). The staff member entering the care planning decision information must also sign and date the RAP Summary form at VB3 and VB4, the Care Plan Completion Date.

1.16 Attestation Statement of Accuracy

The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS information is the basis for:

- The development of an individualized care plan for the resident occurs directly from responses entered on the MDS,
- Medicare Prospective Payment System,
- State Medicaid reimbursement programs,
- Quality monitoring activities such as the Quality Indicator (QI) Reports, the data driven survey and certification process, and the quality measures used for public reporting,
- Research, and
- Policy development.

Primary responsibility for accuracy lies with the person selecting the MDS item response. Each person completing a section of the MDS is required to sign the Attestation Statement (AA9, AD, and AT7) that reads:

> "I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from Federal funds. I further understand that payment of such Federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

In addition, the RN coordinating the assessment must sign and date the MDS. The signature of the RN attests to the completeness of the document. Each staff member who completes any portion of the MDS must sign and date the MDS and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN assessment coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN assessment coordinator is not certifying the accuracy of assessments that were completed by other health professionals.

1.17 Correcting The MDS

Once completed, edited, and accepted into the MDS data repository, facilities may not "change" a previously completed MDS form as the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. However, it is important to remember that the electronic record submitted to and accepted into the MDS database is the legal assessment. Changes made to the electronic record after data transmission or to the paper copy maintained in the medical record are not recognized as proper corrections. The MDS correction process is described in Chapter 5.

However, several additional processes have been put into place to assure that the MDS data is accurate both at the facility and in the State MDS database:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.

- Software used in the facility to encode the MDS must run all standard edits as defined in the data specifications released by CMS.

- Enhanced record rejection standards have been implemented in the State MDS database. If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent, e.g., a skip pattern is not observed, the record is rejected. Inaccurate data is not added to the State MDS database.

- If an error is discovered in a record in the State MDS database, Modification or Inactivation procedures must be implemented by the facility to assure that the database information is corrected.

- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed. A Significant Change in Status assessment or a Significant Correction of a Prior assessment may be needed as well as corrections to the information in the State MDS database.

1.18 Reproduction and Maintenance of the Assessments

A hard copy of all MDS forms within the last 15 months, including the signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record. This applies to all nursing facilities.

Until such time as CMS adopts an electronic signature standard that is compatible with pending Health Insurance Standards Accountability Act (HIPAA) requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS. We understand that the industry is eager to use electronic signatures, and we are just as eager to enable that capability. We plan to implement this as soon as CMS adopts an electronic signature standard, and the standard system is upgraded to enable compliance.

There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed, and dated within the regulatory time frames, and maintained for 15 months in the resident's active record. If changes are made after completion, those changes must be made to the MDS record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment record. Resident assessment forms must accurately reflect the resident's status, and agree with the record that is submitted to the CMS standard system at the state. Please see Chapter 5 for detailed instructions on correcting MDS data.

Facilities are required to maintain 15 months of assessment data in the resident's active clinical record according to CMS policy. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The **exception** is that face sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged.

The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, but the 15-month requirement for maintenance of the RAI data does not restart with each new admission.

In cases where the resident returns to the facility after a long break in care (e.g., 14½ months), staff may want to review the older record to familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirements.

For additional information, refer to Resident Assessment Requirements for Long-Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ④ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

④ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- MR/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(*Code for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?

0. No 1. Yes

10. CONDITIONS RELATED TO MR/DD STATUS

(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*)

- Not applicable—no MR/DD (Skip to AB11) — a.
- MR/DD with organic condition
  - Down's syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to MR/DD — e.
- MR/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)

(***Check all that apply.*** *If all information UNKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- Use of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- Use of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- Usually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.

UNKNOWN—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE

a. *Last day of MDS observation period*

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

5. MARITAL STATUS

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY

(*Billing Office to indicate;* ***check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT

[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

a. Primary reason for assessment

1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. ***Codes for assessments required for Medicare PPS or the State***

1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN

(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES

(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (**If yes, skip to Section G**)

2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY

(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]***.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS

Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING

(*With hearing appliance, if used*)

0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES

(***Check all that apply*** *during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION

(***Check all used*** *by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY

(*Code for speech in the* ***last 7 days***)

0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING

Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/ books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(***Code for indicators observed in last 30 days, irrespective of the assumed cause***) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS **a.** Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*" **b.** Repetitive questions—e.g., "*Where do I go; What do I do?*" **c.** Repetitive verbalizations—e.g., calling out for help, ("*God help me*") **d.** Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received **e.** Self deprecation—e.g., "*I am nothing; I am of no use to anyone*" **f.** Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others **g.** Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions **i.** Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues **SLEEP-CYCLE ISSUES** **j.** Unpleasant mood in morning **k.** Insomnia/change in usual sleep pattern **SAD, APATHETIC, ANXIOUS APPEARANCE** **l.** Sad, pained, worried facial expressions—e.g., furrowed brows **m.** Crying, tearfulness **n.** Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking **LOSS OF INTEREST** **o.** Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends **p.** Reduced social interaction	
2.	MOOD PERSISTENCE	**One or more indicators** of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4.	BEHAVIORAL SYMPTOMS	**(A)** ***Behavioral*** *symptom* ***frequency in last 7 days*** 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily **(B)** ***Behavioral*** *symptom* ***alterability in last 7 days*** 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	**(A)** **(B)**
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

Resident _____ Numeric Identifier _____

2.	**BATHING**	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance and support.* **(A)** BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (*Bathing support codes are as defined in* ***Item 1, code B above***)	(A) (B)
3.	**TEST FOR BALANCE** **(see training manual)**	(*Code for ability during test in the* ***last 7 days***) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help **a.** Balance while standing **b.** Balance while sitting—position, trunk control	
4.	**FUNCTIONAL LIMITATION IN RANGE OF MOTION** **(see training manual)**	(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed resident at risk of injury*) **(A)** *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides **(B)** *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss **a.** Neck **b.** Arm—Including shoulder or elbow **c.** Hand—Including wrist or fingers **d.** Leg—Including hip or knee **e.** Foot—Including ankle or toes **f.** Other limitation or loss	(A) (B)
5.	**MODES OF LOCOMOTION**	(***Check all that apply*** *during* ***last 7 days***) Cane/walker/crutch **a.** Wheeled self **b.** Other person wheeled **c.** Wheelchair primary mode of locomotion **d.** *NONE OF ABOVE* **e.**	
6.	**MODES OF TRANSFER**	(***Check all that apply*** *during* ***last 7 days***) Bedfast all or most of time **a.** Bed rails used for bed mobility or transfer **b.** Lifted manually **c.** Lifted mechanically **d.** Transfer aid (e.g., slide board, trapeze, cane, walker, brace) **e.** *NONE OF ABOVE* **f.**	
7.	**TASK SEGMENTATION**	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes	
8.	**ADL FUNCTIONAL REHABILITATION POTENTIAL**	Resident believes he/she is capable of increased independence in at least some ADLs **a.** Direct care staff believe resident is capable of increased independence in at least some ADLs **b.** Resident able to perform tasks/activity but is very slow **c.** Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings **d.** *NONE OF ABOVE* **e.**	
9.	**CHANGE IN ADL FUNCTION**	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION H. CONTINENCE IN LAST 14 DAYS

1.		CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***) 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	**BOWEL CONTINENCE**	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	**BLADDER CONTINENCE**	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2.	**BOWEL ELIMINATION PATTERN**	Bowel elimination pattern regular—at least one movement every three days **a.** Constipation **b.** Diarrhea **c.** Fecal impaction **d.** *NONE OF ABOVE* **e.**	

3.	**APPLIANCES AND PROGRAMS**	Any scheduled toileting plan	**a.**	Did not use toilet room/ commode/urinal	**f.**
		Bladder retraining program	**b.**	Pads/briefs used	**g.**
		External (condom) catheter	**c.**	Enemas/irrigation	**h.**
		Indwelling catheter	**d.**	Ostomy present	**i.**
		Intermittent catheter	**e.**	*NONE OF ABOVE*	**j.**
4.	**CHANGE IN URINARY CONTINENCE**	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated			

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	**DISEASES**	(***If none apply, CHECK the NONE OF ABOVE box***)			
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	**v.**
		Diabetes mellitus	**a.**	Multiple sclerosis	**w.**
		Hyperthyroidism	**b.**	Paraplegia	**x.**
		Hypothyroidism	**c.**	Parkinson's disease	**y.**
		HEART/CIRCULATION		Quadriplegia	**z.**
		Arteriosclerotic heart disease (ASHD)	**d.**	Seizure disorder	**aa.**
		Cardiac dysrhythmias	**e.**	Transient ischemic attack (TIA)	**bb.**
		Congestive heart failure	**f.**	Traumatic brain injury	**cc.**
		Deep vein thrombosis	**g.**	**PSYCHIATRIC/MOOD**	
		Hypertension	**h.**	Anxiety disorder	**dd.**
		Hypotension	**i.**	Depression	**ee.**
		Peripheral vascular disease	**j.**	Manic depression (bipolar disease)	**ff.**
		Other cardiovascular disease	**k.**	Schizophrenia	**gg.**
		MUSCULOSKELETAL		**PULMONARY**	
		Arthritis	**l.**	Asthma	**hh.**
		Hip fracture	**m.**	Emphysema/COPD	**ii.**
		Missing limb (e.g., amputation)	**n.**	**SENSORY**	
		Osteoporosis	**o.**	Cataracts	**jj.**
		Pathological bone fracture	**p.**	Diabetic retinopathy	**kk.**
		NEUROLOGICAL		Glaucoma	**ll.**
		Alzheimer's disease	**q.**	Macular degeneration	**mm.**
		Aphasia	**r.**	**OTHER**	
		Cerebral palsy	**s.**	Allergies	**nn.**
		Cerebrovascular accident (stroke)	**t.**	Anemia	**oo.**
		Dementia other than Alzheimer's disease	**u.**	Cancer	**pp.**
				Renal failure	**qq.**
				NONE OF ABOVE	**rr.**
2.	**INFECTIONS**	(***If none apply, CHECK the NONE OF ABOVE box***)			
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	**a.**	Septicemia	**g.**
		Clostridium difficile (c. diff.)	**b.**	Sexually transmitted diseases	**h.**
		Conjunctivitis	**c.**	Tuberculosis	**i.**
		HIV infection	**d.**	Urinary tract infection **in last 30 days**	**j.**
		Pneumonia	**e.**	Viral hepatitis	**k.**
		Respiratory infection	**f.**	Wound infection	**l.**
				NONE OF ABOVE	**m.**
3.	**OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES**	a. _____			
		b. _____			
		c. _____			
		d. _____			
		e. _____			

SECTION J. HEALTH CONDITIONS

1.	**PROBLEM CONDITIONS**	(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)			
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo	**f.**
		Weight gain or loss of 3 or more pounds within a 7 day period	**a.**	Edema	**g.**
		Inability to lie flat due to shortness of breath	**b.**	Fever	**h.**
		Dehydrated; output exceeds input	**c.**	Hallucinations	**i.**
		Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	**d.**	Internal bleeding	**j.**
		OTHER		Recurrent lung aspirations in **last 90 days**	**k.**
		Delusions	**e.**	Shortness of breath	**l.**
				Syncope (fainting)	**m.**
				Unsteady gait	**n.**
				Vomiting	**o.**
				NONE OF ABOVE	**p.**

Resident _____ Numeric Identifier _____

2.	**PAIN SYMPTOMS**	(*Code the **highest level of pain** present in the **last 7 days***)	
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily	**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3.	**PAIN SITE**	(*If pain present, **check all sites** that apply in **last 7 days***)	
		Back pain **a.** Bone pain **b.** Chest pain while doing usual activities **c.** Headache **d.** Hip pain **e.**	Incisional pain **f.** Joint pain (other than hip) **g.** Soft tissue pain (e.g., lesion, muscle) **h.** Stomach pain **i.** Other **j.**
4.	**ACCIDENTS**	(***Check all that apply***)	
		Fell in **past 30 days** **a.** Fell in **past 31-180 days** **b.**	Hip fracture in **last 180 days** **c.** Other fracture in **last 180 days** **d.** *NONE OF ABOVE* **e.**
5.	**STABILITY OF CONDITIONS**	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) **a.** Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.** End-stage disease, 6 or fewer months to live **c.** *NONE OF ABOVE* **d.**	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	**ORAL PROBLEMS**	Chewing problem **a.** Swallowing problem **b.** Mouth pain **c.** *NONE OF ABOVE* **d.**	
2.	**HEIGHT AND WEIGHT**	*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* **a.** HT (in.) ☐☐ **b.** WT (lb.) ☐☐☐	
3.	**WEIGHT CHANGE**	**a. Weight loss**—5 % or more in l**ast 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes **b. Weight gain**—5 % or more in l**ast 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes	
4.	**NUTRITIONAL PROBLEMS**	Complains about the taste of many foods **a.** Regular or repetitive complaints of hunger **b.**	Leaves 25% or more of food uneaten at most meals **c.** *NONE OF ABOVE* **d.**
5.	**NUTRITIONAL APPROACHES**	(***Check all that apply in last 7 days***)	
		Parenteral/IV **a.** Feeding tube **b.** Mechanically altered diet **c.** Syringe (oral feeding) **d.** Therapeutic diet **e.**	Dietary supplement between meals **f.** Plate guard, stabilized built-up utensil, etc. **g.** On a planned weight change program **h.** *NONE OF ABOVE* **i.**
6.	**PARENTERAL OR ENTERAL INTAKE**	(***Skip to Section L if neither 5a nor 5b is checked***) **a.** Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% **b.** Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	**ORAL STATUS AND DISEASE PREVENTION**	Debris (soft, easily movable substances) present in mouth prior to going to bed at night **a.** Has dentures or removable bridge **b.** Some/all natural teeth lost—does not have or does not use dentures (or partial plates) **c.** Broken, loose, or carious teeth **d.** Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes **e.** Daily cleaning of teeth/dentures or daily mouth care—by resident or staff **f.** *NONE OF ABOVE* **g.**	

SECTION M. SKIN CONDITION

1.	**ULCERS (Due to any cause)**	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***	**Number at Stage**
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	**TYPE OF ULCER**	(*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	**HISTORY OF RESOLVED ULCERS**	Resident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes	
4.	**OTHER SKIN PROBLEMS OR LESIONS PRESENT**	(***Check all that apply** during **last 7 days***)	
		Abrasions, bruises **a.** Burns (second or third degree) **b.** Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) **c.** Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster **d.** Skin desensitized to pain or pressure **e.** Skin tears or cuts (other than surgery) **f.** Surgical wounds **g.** *NONE OF ABOVE* **h.**	
5.	**SKIN TREATMENTS**	(***Check all that apply** during **last 7 days)***	
		Pressure relieving device(s) for chair **a.** Pressure relieving device(s) for bed **b.** Turning/repositioning program **c.** Nutrition or hydration intervention to manage skin problems **d.** Ulcer care **e.** Surgical wound care **f.** Application of dressings (with or without topical medications) other than to feet **g.** Application of ointments/medications (other than to feet) **h.** Other preventative or protective skin care (other than to feet) **i.** *NONE OF ABOVE* **j.**	
6.	**FOOT PROBLEMS AND CARE**	(***Check all that apply** during **last 7 days)***	
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems **a.** Infection of the foot—e.g., cellulitis, purulent drainage **b.** Open lesions on the foot **c.** Nails/calluses trimmed during **last 90 days** **d.** Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) **e.** Application of dressings (with or without topical medications) **f.** *NONE OF ABOVE* **g.**	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	**TIME AWAKE**	(***Check appropriate time periods over last 7 days***) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning **a.** Afternoon **b.**	Evening **c.** *NONE OF ABOVE* **d.**
(If resident is comatose, skip to Section O)			
2.	**AVERAGE TIME INVOLVED IN ACTIVITIES**	(**When awake and not receiving treatments or ADL care**) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3.	**PREFERRED ACTIVITY SETTINGS**	(***Check all settings** in which activities are **preferred***)	
		Own room **a.** Day/activity room **b.** Inside NH/off unit **c.**	Outside facility **d.** *NONE OF ABOVE* **e.**
4.	**GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)**	(***Check all PREFERENCES** whether or not activity is currently available to resident*)	
		Cards/other games **a.** Crafts/arts **b.** Exercise/sports **c.** Music **d.** Reading/writing **e.** Spiritual/religious activities **f.**	Trips/shopping **g.** Walking/wheeling outdoors **h.** Watching TV **i.** Gardening or plants **j.** Talking or conversing **k.** Helping others **l.** *NONE OF ABOVE* **m.**

Resident _____ Numeric Identifier _____

5. PREFERS CHANGE IN DAILY ROUTINE

Code for resident preferences in daily routines
0. No change 1. Slight change 2. Major change

a. Type of activities in which resident is currently involved
b. Extent of resident involvement in activities

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

2. NEW MEDICATIONS (*Resident currently receiving medications that were initiated during the* ***last 90 days***)
0. No 1. Yes

3. INJECTIONS (***Record the number of DAYS*** *injections of any type received during the* ***last 7 days****; enter "0" if none used*)

4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic
b. Antianxiety
c. Antidepressant
d. Hypnotic
e. Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check*** *treatments or programs received during the* ***last 14 days***

TREATMENTS
Chemotherapy — a.
Dialysis — b.
IV medication — c.
Intake/output — d.
Monitoring acute medical condition — e.
Ostomy care — f.
Oxygen therapy — g.
Radiation — h.
Suctioning — i.
Tracheostomy care — j.
Transfusions — k.
Ventilator or respirator — l.

PROGRAMS
Alcohol/drug treatment program — m.
Alzheimer's/dementia special care unit — n.
Hospice care — o.
Pediatric unit — p.
Respite care — q.
Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
NONE OF ABOVE — s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]

	DAYS (A)	MIN (B)
(A) = # of days administered for **15 minutes or more**		
(B) = total # of minutes provided in **last 7 days**		
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS (**Check all interventions or strategies used in last 7 days**—no matter where received)

Special behavior symptom evaluation program — a.
Evaluation by a licensed mental health specialist in **last 90 days** — b.
Group therapy — c.
Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage — d.
Reorientation—e.g., cueing — e.
NONE OF ABOVE — f.

3. NURSING REHABILITATION/ RESTORATIVE CARE *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was* ***provided to the resident for more than or equal to 15 minutes per day in the last 7 days*** *(Enter 0 if none or less than 15 min. daily.)*

a. Range of motion (passive)
b. Range of motion (active)
c. Splint or brace assistance
TRAINING AND SKILL PRACTICE IN:
d. Bed mobility
e. Transfer
f. Walking
g. Dressing or grooming
h. Eating or swallowing
i. Amputation/prosthesis care
j. Communication
k. Other

4. DEVICES AND RESTRAINTS (*Use the following codes for* ***last 7 days***:)
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

5. HOSPITAL STAY(S) Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)

6. EMERGENCY ROOM (ER) VISIT(S) Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)

7. PHYSICIAN VISITS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

8. PHYSICIAN ORDERS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

9. ABNORMAL LAB VALUES Has the resident had any abnormal lab values during the **last 90 days** (or since admission)?
0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
0. No 1. Yes

b. Resident has a support person who is positive towards discharge
0. No 1. Yes

c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death)
0. No 2. Within 31-90 days
1. Within 30 days 3. Discharge status uncertain

2. OVERALL CHANGE IN CARE NEEDS Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT

a. Resident: 0. No 1. Yes
b. Family: 0. No 1. Yes 2. No family
c. Significant other: 0. No 1. Yes 2. None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month — Day — Year

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS	MIN
(A)	(B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*?
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.***)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     — Complications and risk factors that affect your decision to proceed to care planning.
     — Factors that must be considered in developing individualized care plan interventions.
     — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____

1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

_____

3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier _____

A1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

a. Last day of MDS observation period

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** **[*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].**

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. S*OMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)

VERBAL EXPRESSIONS OF DISTRESS

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

E2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**

0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS

(A) *Behavioral* *symptom* *frequency in last 7 days*

0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral* *symptom* *alterability in last 7 days*

0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

		(A)
a.	**BED MOBILITY** How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	**TRANSFER** How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c.	**WALK IN ROOM** How resident walks between locations in his/her room.	
d.	**WALK IN CORRIDOR** How resident walks in corridor on unit.	
e.	**LOCOMOTION ON UNIT** How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	**LOCOMOTION OFF UNIT** How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	**DRESSING** How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis	
h.	**EATING** How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

Resident_____ Numeric Identifier _____

i. TOILET USE — How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes

j. PERSONAL HYGIENE — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

G2. BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)
Code for most dependent *in self-performance.*
(A) BATHING SELF PERFORMANCE codes appear below

(A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION — (*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER — (***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time **a.** | Bed rails used for bed mobility or transfer **b.** | *NONE OF ABOVE* **f.**

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a. BOWEL CONTINENCE — Control of bowel movement, with appliance or bowel continence programs, if employed

b. BLADDER CONTINENCE — Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN — Fecal impaction **d.** | *NONE OF ABOVE* **e.**

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	**a.**	Indwelling catheter	**d.**
Bladder retraining program	**b.**	Ostomy present	**i.**
External (condom) catheter	**c.**	*NONE OF ABOVE*	**j.**

I2. INFECTIONS — Urinary tract infection **in last 30 days** **j.** | *NONE OF ABOVE* **m.**

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES — (*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |

b. _____ | | | | • | |

J1. PROBLEM CONDITIONS — (***Check all problems present*** *in* ***last 7 days***)

Dehydrated; output exceeds input **c.** | Hallucinations **i.** | *NONE OF ABOVE* **p.**

J2. PAIN SYMPTOMS — (*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS — (***Check all that apply***)

Fell in **past 30 days** **a.** | Fell in **past 31-180 days** **b.** | Hip fracture in **last 180 days** **c.** | Other fracture in **last 180 days** **d.** | *NONE OF ABOVE* **e.**

J5. STABILITY OF CONDITIONS — Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) **a.**
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.**
End-stage disease, 6 or fewer months to live **c.**
NONE OF ABOVE **d.**

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

K5. NUTRITIONAL APPROACHES

Feeding tube **b.**
On a planned weight change program **h.**
NONE OF ABOVE **i.**

M1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during* ***last 7 days****. Code 9 = 9 or more.)* ***[Requires full body exam.]***

	Number at Stage
a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER — (*For each type of ulcer,* ***code for the highest stage in the last 7 days*** *using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue

b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

N1. TIME AWAKE — (***Check appropriate time periods over last 7 days***)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
Morning **a.** | Evening **c.** | Afternoon **b.** | *NONE OF ABOVE* **d.**

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES — (**When awake and not receiving treatments or ADL care**)
0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS — (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION — (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic | **b.** Antianxiety | **c.** Antidepressant | **d.** Hypnotic | **e.** Diuretic

P4. DEVICES AND RESTRAINTS — *Use the following codes for* ***last 7 days***:
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month ___ Day ___ Year ____

Numeric Identifier _____

MDS QUARTERLY ASSESSMENT FORM
(OPTIONAL VERSION FOR RUG-III)

A1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

a. Last day of MDS observation period

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

A4. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE (*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY (*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY (***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season **a.**
Location of own room **b.**
Staff names/faces **c.**
That he/she is in a nursing home **d.**
NONE OF ABOVE are recalled **e.**

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*****].**

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD (*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS (*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (***Code for indicators observed in last 30 days, irrespective of the assumed cause***)

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

E2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**

0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS

(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. **(A)** ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

		(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY** How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER** How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

Resident_____ Numeric Identifier _____

G1. (A) (B)

c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below — (A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G3. TEST FOR BALANCE (see training manual) — (*Code for ability during test in the* ***last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing
b. Balance while sitting—position, trunk control

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER — (***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time **a.** — *NONE OF ABOVE* **f.**
Bed rails used for bed mobility or transfer **b.**

G7. TASK SEGMENTATION — Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them. 0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN — Diarrhea **c.** — *NONE OF ABOVE* **e.**; Fecal impaction **d.**

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan **a.**
Bladder retraining program **b.**
External (condom) catheter **c.**
Indwelling catheter **d.**
Ostomy present **i.**
NONE OF ABOVE **j.**

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

I1. DISEASES (***If none apply, CHECK the NONE OF ABOVE box***)

MUSCULOSKELETAL
Hip fracture **m.**
NEUROLOGICAL
Aphasia **r.**
Cerebral palsy **s.**
Cerebrovascular accident (stroke) **t.**
Hemiplegia/Hemiparesis **v.**
Multiple sclerosis **w.**
Quadriplegia **z.**
PSYCHIATRIC/MOOD
Depression **ee.**
Manic depressive (bipolar disease) **ff.**
OTHER
NONE OF ABOVE **rr.**

I2. INFECTIONS (***If none apply, CHECK the NONE OF ABOVE box***)

Antibiotic resistant infection (e.g., Methicillin resistant staph) **a.**
Clostridium difficile (c. diff.) **b.**
Conjunctivitis **c.**
HIV infection **d.**
Pneumonia **e.**
Respiratory infection **f.**
Septicemia **g.**
Sexually transmitted diseases **h.**
Tuberculosis **i.**
Urinary tract infection **in last 30 days** **j.**
Viral hepatitis **k.**
Wound infection **l.**
NONE OF ABOVE **m.**

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES (*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |
b. | | | | • | |

J1. PROBLEM CONDITIONS (***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)

INDICATORS OF FLUID STATUS
Weight gain or loss of 3 or more pounds within a 7 day period **a.**
Inability to lie flat due to shortness of breath **b.**
Dehydrated; output exceeds input **c.**
Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days** **d.**

OTHER
Delusions **e.**
Edema **g.**
Fever **h.**
Hallucinations **i.**
Internal bleeding **j.**
Recurrent lung aspirations in **last 90 days** **k.**
Shortness of breath **l.**
Unsteady gait **n.**
Vomiting **o.**
NONE OF ABOVE **p.**

J2. PAIN SYMPTOMS (*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS (***Check all that apply***)

Fell in **past 30 days** **a.**
Fell in **past 31-180 days** **b.**
Hip fracture in **last 180 days** **c.**
Other fracture in **last 180 days** **d.**
NONE OF ABOVE **e.**

J5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) **a.**
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.**
End-stage disease, 6 or fewer months to live **c.**
NONE OF ABOVE **d.**

K1. ORAL PROBLEMS

Chewing problem **a.**
Swallowing problem **b.**
NONE OF ABOVE **d.**

K2. HEIGHT AND WEIGHT — *Record* ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 30 days****; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**. 0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**. 0. No 1. Yes

Resident_____ Numeric Identifier _____

K5. NUTRITIONAL APPROACHES — (***Check all that apply in last 7 days***)

- Parenteral/IV — a.
- Feeding tube — b.
- On a planned weight change program — h.
- *NONE OF ABOVE* — i.

M1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***

		Number at Stage
a.	Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b.	Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c.	Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d.	Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER — (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

- a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
- b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT — (***Check all that apply** during **last 7 days***)

- Abrasions, bruises — a.
- Burns (second or third degree) — b.
- Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) — c.
- Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster — d.
- Skin desensitized to pain or pressure — e.
- Skin tears or cuts (other than surgery) — f.
- Surgical wounds — g.
- *NONE OF ABOVE* — h.

M5. SKIN TREATMENTS — (***Check all that apply** during **last 7 days**)*

- Pressure relieving device(s) for chair — a.
- Pressure relieving device(s) for bed — b.
- Turning/repositioning program — c.
- Nutrition or hydration intervention to manage skin problems — d.
- Ulcer care — e.
- Surgical wound care — f.
- Application of dressings (with or without topical medications) other than to feet — g.
- Application of ointments/medications (other than to feet) — h.
- Other preventative or protective skin care (other than to feet) — i.
- *NONE OF ABOVE* — j.

M6. FOOT PROBLEMS AND CARE — (***Check all that apply** during **last 7 days**)*

- Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems — a.
- Infection of the foot—e.g., cellulitis, purulent drainage — b.
- Open lesions on the foot — c.
- Nails/calluses trimmed during **last 90 days** — d.
- Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) — e.
- Application of dressings (with or without topical medications) — f.
- *NONE OF ABOVE* — g.

N1. TIME AWAKE — (***Check appropriate time periods over last 7 days***)

Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

- Morning — a.
- Afternoon — b.
- Evening — c.
- *NONE OF ABOVE* — d.

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES — (**When awake and not receiving treatments or ADL care**)

0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS — (***Record the number of different** medications used in the **last 7 days**; enter "0" if none used*)

O3. INJECTIONS — (***Record the number of DAYS** injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION — (***Record the number of DAYS** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- a. Antipsychotic — d. Hypnotic
- b. Antianxiety — e. Diuretic
- c. Antidepressant

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS — a. **SPECIAL CARE**—***Check** treatments or programs received during the **last 14 days***

TREATMENTS

- Chemotherapy — a.
- Dialysis — b.
- IV medication — c.
- Intake/output — d.
- Monitoring acute medical condition — e.
- Ostomy care — f.
- Oxygen therapy — g.
- Radiation — h.
- Suctioning — i.
- Tracheostomy care — j.
- Transfusions — k.
- Ventilator or respirator — l.

PROGRAMS

- Alcohol/drug treatment program — m.
- Alzheimer's/dementia special care unit — n.
- Hospice care — o.
- Pediatric unit — p.
- Respite care — q.
- Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
- *NONE OF ABOVE* — s.

b. **THERAPIES** - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]**

(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in **last 7 days**

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE — *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

- a. Range of motion (passive)
- b. Range of motion (active)
- c. Splint or brace assistance

TRAINING AND SKILL PRACTICE IN:

- d. Bed mobility
- e. Transfer
- f. Walking
- g. Dressing or grooming
- h. Eating or swallowing
- i. Amputation/prosthesis care
- j. Communication
- k. Other

P4. DEVICES AND RESTRAINTS — *Use the following codes for **last 7 days**:*
0. Not used
1. Used less than daily
2. Used daily

Bed rails

- a. — Full bed rails on all open sides of bed
- b. — Other types of side rails used (e.g., half rail, one side)
- c. Trunk restraint
- d. Limb restraint
- e. Chair prevents rising

P7. PHYSICIAN VISITS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

P8. PHYSICIAN ORDERS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)

0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month ___ Day ___ Year ____

MDS QUARTERLY ASSESSMENT FORM
(OPTIONAL VERSION FOR RUG-III 1997 Update)

Numeric Identifier _____

A1. RESIDENT NAME
a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE
a. Last day of MDS observation period
Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)
Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE
(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY
(*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY
(***Check all*** *that resident was* ***normally able to recall during last 7 days***)
Current season **a.**
Location of own room **b.**
Staff names/faces **c.**
That he/she is in a nursing home **d.**
NONE OF ABOVE are recalled **e.**

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS
(*Code for behavior in the* ***last 7 days.)*** **[*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].**
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD
(*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS
(*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD
(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS
a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"
b. Repetitive questions—e.g., "*Where do I go; What do I do?*"
c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES
j. Unpleasant mood in morning
k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE
l. Sad, pained, worried facial expressions—e.g., furrowed brows
m. Crying, tearfulness
n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST
o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
p. Reduced social interaction

E2. MOOD PERSISTENCE
One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS
(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. **(A)** ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days***—*Not including setup*)
0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY**	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER**	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

Resident_____ Numeric Identifier _____

G1.			(A)	(B)
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below

	(A)
0. Independent—No help provided	
1. Supervision—Oversight help only	
2. Physical help limited to transfer only	
3. Physical help in part of bathing activity	
4. Total dependence	
8. Activity itself did not occur during entire 7 days	

G3. TEST FOR BALANCE (see training manual)

(*Code for ability during test in the* ***last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing	
b. Balance while sitting—position, trunk control	

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*
0. No limitation
1. Limitation on one side
2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*
0. No loss
1. Partial loss
2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER

(***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time	a.	*NONE OF ABOVE*	f.
Bed rails used for bed mobility or transfer	b.		

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them
0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

H2. BOWEL ELIMINATION PATTERN

Diarrhea	c.	*NONE OF ABOVE*	e.
Fecal impaction	d.		

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	a.	Indwelling catheter	d.
Bladder retraining program	b.	Ostomy present	i.
External (condom) catheter	c.	*NONE OF ABOVE*	j.

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

I1. DISEASES (***If none apply, CHECK the NONE OF ABOVE box***)

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
Diabetes mellitus	a.	Multiple sclerosis	w.
MUSCULOSKELETAL		Quadriplegia	z.
Hip fracture	m.	**PSYCHIATRIC/MOOD**	
NEUROLOGICAL		Depression	ee.
Aphasia	r.	Manic depressive (bipolar disease)	ff.
Cerebral palsy	s.	**OTHER**	
Cerebrovascular accident (stroke)	t.	*NONE OF ABOVE*	rr.

I2. INFECTIONS (***If none apply, CHECK the NONE OF ABOVE box***)

Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Sexually transmitted diseases	h.
Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
Conjunctivitis	c.	Urinary tract infection **in last 30 days**	j.
HIV infection	d.	Viral hepatitis	k.
Pneumonia	e.	Wound infection	l.
Respiratory infection	f.	NONE OF ABOVE	m.

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

(*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |

b. | | | | • | |

J1. PROBLEM CONDITIONS

(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)

INDICATORS OF FLUID STATUS		**OTHER**	
Weight gain or loss of 3 or more pounds within a 7 day period	a.	Delusions	e.
		Edema	g.
Inability to lie flat due to shortness of breath	b.	Fever	h.
		Hallucinations	i.
Dehydrated; output exceeds input	c.	Internal bleeding	j.
		Recurrent lung aspirations in **last 90 days**	k.
Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	d.	Shortness of breath	l.
		Unsteady gait	n.
		Vomiting	o.
		NONE OF ABOVE	p.

J2. PAIN SYMPTOMS

(*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS

(***Check all that apply***)

Fell in **past 30 days**	a.	Hip fracture in **last 180 days**	c.
		Other fracture in **last 180 days**	d.
Fell in **past 31-180 days**	b.	*NONE OF ABOVE*	e.

J5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)	a.
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
End-stage disease, 6 or fewer months to live	c.
NONE OF ABOVE	d.

K1. ORAL PROBLEMS

Chewing problem	a.
Swallowing problem	b.
NONE OF ABOVE	d.

K2. HEIGHT AND WEIGHT

Record ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 30 days****; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

Resident_____ Numeric Identifier _____

K5. NUTRITIONAL APPROACHES (***Check all that apply in last 7 days***)

- a. Parenteral/IV
- b. Feeding tube
- On a planned weight change program → h.
- *NONE OF ABOVE* → i.

K6. PARENTERAL OR ENTERAL INTAKE (***Skip to Section M if neither 5a nor 5b is checked***)

a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days**
0. None; 1. 1% to 25%; 2. 26% to 50%; 3. 51% to 75%; 4. 76% to 100%

b. Code the average **fluid intake** per day by IV or tube in **last 7 days**
0. None; 1. 1 to 500 cc/day; 2. 501 to 1000 cc/day; 3. 1001 to 1500 cc/day; 4. 1501 to 2000 cc/day; 5. 2001 or more cc/day

M1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***

		Number at Stage
a. Stage 1.	A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2.	A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3.	A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4.	A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

- **a.** Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
- **b.** Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT (***Check all that apply** during **last 7 days***)

- Abrasions, bruises → a.
- Burns (second or third degree) → b.
- Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) → c.
- Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster → d.
- Skin desensitized to pain or pressure → e.
- Skin tears or cuts (other than surgery) → f.
- Surgical wounds → g.
- *NONE OF ABOVE* → h.

M5. SKIN TREATMENTS (***Check all that apply** during **last 7 days)***

- Pressure relieving device(s) for chair → a.
- Pressure relieving device(s) for bed → b.
- Turning/repositioning program → c.
- Nutrition or hydration intervention to manage skin problems → d.
- Ulcer care → e.
- Surgical wound care → f.
- Application of dressings (with or without topical medications) other than to feet → g.
- Application of ointments/medications (other than to feet) → h.
- Other preventative or protective skin care (other than to feet) → i.
- *NONE OF ABOVE* → j.

M6. FOOT PROBLEMS AND CARE (***Check all that apply** during **last 7 days)***

- Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems → a.
- Infection of the foot—e.g., cellulitis, purulent drainage → b.
- Open lesions on the foot → c.
- Nails/calluses trimmed during **last 90 days** → d.
- Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) → e.
- Application of dressings (with or without topical medications) → f.
- *NONE OF ABOVE* → g.

N1. TIME AWAKE (***Check appropriate time periods over last 7 days***)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

- a. Morning
- b. Afternoon
- Evening → c.
- *NONE OF ABOVE* → d.

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES (**When awake and not receiving treatments or ADL care**)
0. Most—more than 2/3 of time; 1. Some—from 1/3 to 2/3 of time; 2. Little—less than 1/3 of time; 3. None

O1. NUMBER OF MEDICATIONS (***Record the number of different** medications used in the **last 7 days**; enter "0" if none used*)

O3. INJECTIONS (***Record the number of DAYS** injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- **a.** Antipsychotic
- **b.** Antianxiety
- **c.** Antidepressant
- **d.** Hypnotic
- **e.** Diuretic

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check** treatments or programs received during the **last 14 days***

TREATMENTS
- Chemotherapy → a.
- Dialysis → b.
- IV medication → c.
- Intake/output → d.
- Monitoring acute medical condition → e.
- Ostomy care → f.
- Oxygen therapy → g.
- Radiation → h.
- Suctioning → i.
- Tracheostomy care → j.
- Transfusions → k.
- Ventilator or respirator → l.

PROGRAMS
- Alcohol/drug treatment program → m.
- Alzheimer's/dementia special care unit → n.
- Hospice care → o.
- Pediatric unit → p.
- Respite care → q.
- Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) → r.
- *NONE OF ABOVE* → s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]

(A) = # of days administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days**	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE — *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

- **a.** Range of motion (passive)
- **b.** Range of motion (active)
- **c.** Splint or brace assistance

TRAINING AND SKILL PRACTICE IN:
- **d.** Bed mobility
- **e.** Transfer
- **f.** Walking
- **g.** Dressing or grooming
- **h.** Eating or swallowing
- **i.** Amputation/prosthesis care
- **j.** Communication
- **k.** Other

P4. DEVICES AND RESTRAINTS — *Use the following codes for **last 7 days**:*
0. Not used; 1. Used less than daily; 2. Used daily

Bed rails
- **a.** — Full bed rails on all open sides of bed
- **b.** — Other types of side rails used (e.g., half rail, one side)
- **c.** Trunk restraint
- **d.** Limb restraint
- **e.** Chair prevents rising

P7. PHYSICIAN VISITS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

P8. PHYSICIAN ORDERS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change; 1. Improved—receives fewer supports, needs less restrictive level of care; 2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [*do not use for temporary visits home*]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊛	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ⊛	1. Male 2. Female
3.	BIRTHDATE ⊛	Month — Day — Year
4.	RACE/ ETHNICITY ⊛	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊛ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊛	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ⊛	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

[*Complete only for stays less than 14 days*] (AA8a=8)

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	**a.** *Code for resident disposition upon discharge* 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other **b.** *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* Month — Day — Year

⊛ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ETHNICITY ④	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 9. Reentry

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	**Date of reentry** Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

④ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident **received** during the last 7 days. Include scheduled medications that are used regularly, but less than weekly .

1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.
2. **Route of Administration (RA).** Code the Route of Administration using the following list:

1=by mouth (PO)	5=subcutaneous (SQ)	8=inhalation
2=sub lingual (SL)	6=rectal (R)	9=enteral tube
3=intramuscular (IM)	7=topical	10=other
4=intravenous (IV)		

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary	2D=(BID) two times daily	QO=every other day
1H=(QH) every hour	(includes every 12 hrs)	4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q month) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other

4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) **per dose** administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength , and form. The NDC code must match the drug dispensed by the pharmacy.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes

MDS MEDICARE PPS ASSESSMENT FORM
(VERSION JULY 2002)

Numeric Identifier _____

AB5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry.)*

a. Prior stay at this nursing home
b. Stay in other nursing home
c. Other residential facility—board and care home, assisted living, group home
d. MH/psychiatric setting
e. MR/DD setting
f. *NONE OF ABOVE*

A1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

a. Last day of MDS observation period

Month — Day — Year

A4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

A5. MARITAL STATUS

1. Never married 3. Widowed 5. Divorced
2. Married 4. Separated

A6. MEDICAL RECORD NO.

A10. ADVANCED DIRECTIVES

(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply)***

b. Do not resuscitate **c.** Do not hospitalize

B1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***If Yes, skip to Section G)***

B2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY

(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

a. Current season
b. Location of own room
c. Staff names/faces
d. That he/she is in a nursing home
e. *NONE OF ABOVE* are recalled

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* **last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].**
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

D1. VISION

(*Ability to see in adequate light and with glasses if used*)
0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books
1. *IMPAIRED*—sees large print, but not regular print in newspapers/ books
2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects
3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects
4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(Code for indicators observed in last 30 days, irrespective of the assumed cause)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

E2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**

0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

Resident Identifier _____ Numeric Identifier _____

E4. BEHAVIORAL SYMPTOMS

(A) ***Behavioral** symptom **frequency in last 7 days***

0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral** symptom **alterability in last 7 days***

0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)		

G1. **(A)** ADL SELF-PERFORMANCE—(***Code** for resident's **PERFORMANCE OVER ALL SHIFTS during last 7 days**—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless** of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7days

			(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY**	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER**	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	**WALK IN ROOM**	How resident walks between locations in his/her room		
d.	**WALK IN CORRIDOR**	How resident walks in corridor on unit		
e.	**LOCOMOTION ON UNIT**	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	**LOCOMOTION OFF UNIT**	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	**DRESSING**	How resident puts on, fastens, and takes off all items of **clothing**, including donning/removing prosthesis		
h.	**EATING**	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	**TOILET USE**	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	**PERSONAL HYGIENE**	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent** in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below — (A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G3. TEST FOR BALANCE (see training manual)

(*Code for ability during test in the **last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing
b. Balance while sitting—position, trunk control

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(*Code for limitations during **last 7 days** that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*
0. No limitation
1. Limitation on one side
2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*
0. No loss
1. Partial loss
2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G5. MODES OF LOCOMOTION

(***Check if applied** during **last 7 days***)

b. Wheeled self ☐

G6. MODES OF TRANSFER

(***Check all that apply** during **last 7 days***)

a. Bedfast all or most of time ☐
b. Bed rails used for bed mobility or transfer ☐

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them
0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS)***

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	**BOWEL CONTINENCE**	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	**BLADDER CONTINENCE**	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN

c. Diarrhea
d. Fecal impaction

H3. APPLIANCES AND PROGRAMS

a. Any scheduled toileting plan
b. Bladder retraining program
c. External (condom) catheter
d. Indwelling catheter
i. Ostomy present

For Section I : check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

I1. DISEASES

a. Diabetes melitus
d. Arteriosclerotic heart disease (ASHD)
f. Congestive heart failure
j. Peripheral vascular disease
m. Hip fracture
r. Aphasia
s. Cerebral palsy
t. Cerebrovascular accident (stroke)
v. Hemiplegia/Hemiparesis
w. Multiple sclerosis
x. Paraplegia
z. Quadriplegia
ee. Depression
ff. Manic depressive (bipolar disease)
gg. Schizophrenia
hh. Asthma
ii. Emphysema/COPD

I2. INFECTIONS

(***If none apply, CHECK the NONE OF ABOVE box***)

a. Antibiotic resitant infection **(e.g. Methicillin resistant staph)**
b. Clostridium difficile (c. diff.)
c. Conjunctivitis
d. HIV infection
e. Pneumonia
f. Respiratory infection
g. Septicemia
h. Sexually transmitted diseases
i. Tuberculosis
j. Urinary tract infection **in last 30 days**
k. Viral hepatitis
l. Wound infection
m. NONE OF ABOVE

Resident Identifier _____ Numeric Identifier _____

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

a. _____ | | | | . | |

b. | | | | . | |

J1. PROBLEM CONDITIONS (*Check all problems present in last 7 days unless other time frame is indicated*)

INDICATORS OF FLUID STATUS

- **a.** Weight gain or loss of 3 or more pounds within a 7-day period
- **b.** Inability to lie flat due to shortness of breath
- **c.** Dehydrated; output exceeds input
- **d.** Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**

OTHER

- **e.** Delusions
- **g.** Edema
- **h.** Fever
- **i.** Hallucinations
- **j.** Internal bleeding
- **k.** Recurrent lung aspirations in **last 90 days**
- **l.** Shortness of breath
- **n.** Unsteady gait
- **o.** Vomiting

J2. PAIN SYMPTOMS (*Code the highest level of pain present in the last 7 days*)

a. FREQUENCY with which resident complains or shows evidence of pain

0. No pain (*skip to J4*)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain

1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excruciating

J4. ACCIDENTS (*Check all that apply*)

- **a.** Fell in **past 30 days**
- **b.** Fell in **past 31-180 days**
- **c.** Hip fracture in **last 180 days**
- **d.** Other fracture in **last 180 days**
- **e.** *NONE OF ABOVE*

J5. STABILITY OF CONDITIONS

- **a.** Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)
- **b.** Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem
- **c.** End-stage disease, 6 or fewer months to live
- **d.** *NONE OF ABOVE*

K1. ORAL PROBLEMS

- **a.** Chewing problem
- **b.** Swallowing problem

K2. HEIGHT AND WEIGHT

*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

- **a. Weight loss**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
  0. No 1. Yes
- **b. Weight gain**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
  0. No 1. Yes

K5. NUTRITIONAL APPROACHES (*Check all that apply in last 7 days*)

- **a.** Parenteral/IV
- **b.** Feeding tube
- **h.** On a planned weight change program

K6. PARENTERAL OR ENTERAL INTAKE (*Skip to Section M if neither 5a nor 5b is checked*)

- **a.** Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days**
  0. None
  1. 1% to 25%
  2. 26% to 50%
  3. 51% to 75%
  4. 76% to 100%
- **b.** Code the average **fluid intake** per day by IV or tube in **last 7 days**
  0. None
  1. 1 to 500 cc/day
  2. 501 to 1000 cc/day
  3. 1001 to 1500 cc/day
  4. 1501 to 2000 cc/day
  5. 2001 or more cc/day

M1. ULCERS (Due to any cause)

*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.) **[Requires full body exam.]***

Number at Stage

- **a.** Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- **b.** Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
- **c.** Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.
- **d.** Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

M2. TYPE OF ULCER (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

- **a.** Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
- **b.** Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M3. HISTORY OF RESOLVED ULCERS

Resident had an ulcer that was resolved or cured **in LAST 90 DAYS**
0. No 1. Yes

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT (*Check all that apply during last 7 days*)

- **a.** Abrasions, bruises
- **b.** Burns (second or third degree)
- **c.** Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)
- **d.** Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster
- **e.** Skin desensitized to pain or pressure
- **f.** Skin tears or cuts (other than surgery)
- **g.** Surgical wounds
- **h.** *NONE OF ABOVE*

M5. SKIN TREATMENTS (*Check all that apply during last 7 days*)

- **a.** Pressure relieving device(s) for chair
- **b.** Pressure relieving device(s) for bed
- **c.** Turning/repositioning program
- **d.** Nutrition or hydration intervention to manage skin problems
- **e.** Ulcer care
- **f.** Surgical wound care
- **g.** Application of dressings (with or without topical medications) other than to feet
- **h.** Application of ointments/medications (other than to feet)
- **i.** Other preventative or protective skin care (other than to feet)
- **j.** *NONE OF ABOVE*

M6. FOOT PROBLEMS AND CARE (*Check all that apply during last 7 days*)

- **a.** Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems
- **b.** Infection of the foot—e.g., cellulitis, purulent drainage
- **c.** Open lesions on the foot
- **d.** Nails/calluses trimmed during **last 90 days**
- **e.** Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)
- **f.** Application of dressings (with or without topical medications)
- **g.** *NONE OF ABOVE*

N1. TIME AWAKE (*Check appropriate time periods over last 7 days*)

Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

- **a.** Morning
- **b.** Afternoon
- **c.** Evening
- **d.** *NONE OF ABOVE*

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES (**When awake and not receiving treatments or ADL care**)

0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS (*Record the number of different medications used in the **last 7 days**; enter "0" if none used*)

O3. INJECTIONS (*Record the number of DAYS injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION (*Record the number of DAYS during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- **a.** Antipsychotic
- **b.** Antianxiety
- **c.** Antidepressant
- **d.** Hypnotic
- **e.** Diuretic

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—*Check treatments or programs received during **the last 14 days***

TREATMENTS

- **a.** Chemotherapy
- **b.** Dialysis
- **c.** IV medication
- **d.** Intake/output
- **e.** Monitoring acute medical condition
- **f.** Ostomy care
- **g.** Oxygen therapy
- **h.** Radiation
- **i.** Suctioning
- **j.** Tracheostomy care
- **k.** Transfusions
- **l.** Ventilator or respirator

PROGRAMS

- **m.** Alcohol/drug treatment program
- **n.** Alzheimer's/dementia special care unit
- **o.** Hospice care
- **p.** Pediatric unit
- **q.** Respite care
- **r.** Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)
- **s.** *NONE OF THE ABOVE*

Resident Identifier _____ Numeric Identifier _____

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)*
[Note — count only post admission therapies]
(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in **last 7 days**

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE

*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the residents for more than or equal to 15 minutes per day in the last 7 days** (ENTER 0 if none or less than15 min. daily.)*

a. Range of motion (passive)		**f.** Walking	
b. Range of motion (active)		**g.** Dressing or grooming	
c. Splint or brace assistance		**h.** Eating or swallowing	
TRAINING AND SKILL PRACTICE IN:		**i.** Amputation/prosthesis care	
d. Bed mobility		**j.** Communication	
e. Transfer		**k.** Other	

P4. DEVICES AND RESTRAINTS

*Use the following codes for **last 7 days:***
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. —Full bed rails on all open sides of bed
b. —Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

P7. PHYSICIAN VISITS

In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*

P8. PHYSICIAN ORDERS

In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*

Q1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
0. No 1. Yes

c. Stay projected to be of a short duration—discharge projected **within 90 days** (do not include expected discharge due to death)
0. No 2. Within 31-90 days
1. Within 30 days 3. Discharge status uncertain

Q2. OVERALL CHANGE IN CARE NEEDS

Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)
b. Date RN Assessment Coordinator signed as complete ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

T1. SPECIAL TREATMENTS AND PROCEDURES

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment

b. ORDERED THERAPIES—*Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

c. Through day15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered. ☐☐

d. Through day15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered. ☐☐☐☐☐

T3. CASE MIX GROUP

Medicare ☐☐☐☐☐ State ☐☐☐☐☐